FOR ARGUMENT

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

REPLY BRIEF FOR PETITIONERS

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REPLY BRIEF FOR PETITIONERS

SUMMARY OF ARGUMENT

The sole issue in this case is whether the statutory term "business of insurance," as contained in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-13 (1976) ("McCarran Act"), includes a contract between an insurer and a health care provider to furnish benefits owed to policyholders under the insurer's health care service

benefit policies. In petitioners' initial brief, as well as those of the numerous *amici curiae* in support of reversal, it was fully demonstrated that the Pharmacy Agreement here in issue is functionally inseparable from the insurer-policyholder contract and, therefore, a part of the "business of insurance."

In support of the result reached below, however, the United States as *amicus curiae* seeks to blur the clear-cut distinction between Blue Shield's Pharmacy Agreement and other types of agreements between insurers and non-insurers. The Pharmacy Agreement is not merely a device to contain claims costs and thus reduce rates, as the government contends, although that is an important feature. Rather, the Agreement is the means by which Blue Shield fulfills its basic obligation to furnish policy benefits to its insureds in the form of goods and services rather than cash. The Pharmacy Agreement thus fits within this Court's definition of insurance as a "*guarantee* that at least some fraction of the benefits will be payable in fixed amounts." *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 71 (1959) (emphasis added). The Pharmacy Agreement, moreover, is so necessary to the "type of policy" issued and its enforcement and reliability as to bring it within the "business of insurance." *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969).

Service benefit insurance plans utilizing provider agreements are a distinctive characteristic of the health insurance industry. In contrast to the risks covered by most other types of insurance, medical care is a necessity and the policyholder is therefore vitally interested in receiving full coverage. Health insurers such as Blue Shield have met this policyholder need and have alleviated the financial concerns of insureds by offering coverage in the form of goods and services rather than cash reimbursement, and by assuming the responsibility of paying

for policy benefits. As evidenced by more than twenty state enabling statutes enacted in the 1930s, health service benefit plans are a type of insurance which predated the McCarran Act, and which were in the contemplation of Congress when the Act was passed.

Because the objective of the Pharmacy Agreement is to furnish to insureds the goods and services which are the precise benefits the policy guarantees, the Agreement is far different in concept and operation from other types of agreements between insurers and non-insurers unrelated to the obligation to provide benefits. For this reason, the government is wide of the mark in asserting that petitioners would define the "business of insurance" to include (1) any agreement between insurers and others to lower expenses which might ultimately be reflected in lower premiums or greater solvency, or (2) any agreement to supply insurers (rather than policyholders) with goods and services not comprising policy benefits.

While Blue Shield's Pharmacy Agreements are within the "business of insurance" without the need to inquire into their impact on rates, that impact is an independent ground for finding them to be within the "business of insurance". The government's characterization of effect on rates and solvency as immaterial for purposes of the McCarran Act ignores one of the primary purposes of the Act, to preserve state regulation directed at rate-making and solvency. *Securities and Exchange Commission* v. *National Securities, Inc.*, *supra*, 393 U.S. at 460. The effect of the Pharmacy Agreement on rates and solvency is hardly minimal. The Agreement does not seek to contain the costs of Blue Shield's incidental expenses but the costs of the very goods and services whose purchase is the risk assumed in the contract of insurance. The Agreement is thus an integral part of the rate-making process since rates are principally dependent upon loss experience.

Tacitly repudiating the *National Securities* definition of the insurance business as including the type of policy

issued, its reliability and enforcement, as well as other activities directly affecting rates and solvency, the government proposes new standards, none of which would effectuate the intent of the Act:

1. The government exhibits a fundamental misunderstanding of the insurance business when it attempts to draw a distinction between "risk underwriting" or "risk spreading" and "risk reduction", with so-called "risk spreading" identified as the sole function of insurers and the Pharmacy Agreement categorized as a "risk reduction" device. (Brief for the United States as *Amicus Curiae* ("U.S. Br.") at 15-19) The process of assessing risks in order to determine what obligations an insurer will assume—a process fundamental to the insurance business—necessarily entails efforts to reduce risks and to make them more readily predictable, as Congress recognized when it passed the McCarran Act. Blue Shield's decision to limit the magnitude of the risk covered by the policy and to make it more predictable by means of the Pharmacy Agreement is thus an essential part of the insurer's function, whether it be described as "risk spreading" or "risk reduction". The government, indeed, elsewhere acknowledges that the "formula for the payment of insurance claims"—such as the reimbursement formula contained in the Pharmacy Agreement—"is an integral part of any contract of insurance, because it determines how much risk is involved, and how much of the risk will be assumed by the insurer." (U.S. Br. at 31)

2. The government also misreads the McCarran Act in proposing to immunize horizontal agreements among insurers but not vertical agreements between insurers and health care providers entered into for the sole purpose of furnishing the benefits specified in the insurance policy. (U.S. Br. at 30-33) This standard was rejected by Congress when it refused to limit the exemption to such horizontal activities as rate bureaus and risk-pooling. In terms

of the impact on the policyholder, Blue Shield's arrangements with pharmacies have a much more direct and profound effect than some horizontal arrangements which the government admits to be part of the insurance business, but which affect the insured only indirectly (*e.g.*, insurance association membership rules).

Taking a different approach from that of the government, respondents contend that only those provider agreements having anticompetitive effects are not a part of the "business of insurance". (Brief for Respondents ("Resp. Br.") at 33-35) However, as the government emphasizes (U.S. Br. at 10), this argument confuses the immunity issue with substantive questions of antitrust law, and would neutralize the central purpose of the McCarran Act to exempt activity which might otherwise violate the antitrust laws. Respondents also misconstrue the Act in contending that it was not intended to immunize the acts of non-insurance companies. Unlike other express antitrust exemptions based on the identity of the potential recipient, the McCarran Act, by referring to the "business of insurance" and "every person engaged therein" rather than to "insurance companies", is conduct-oriented. Since the Pharmacy Agreement is conduct within the "business of insurance," both signatories necessarily must be immune to effectuate the Act's purposes.

As an express immunity unique among the federal antitrust exemptions in its subordination of federal regulation to regulation by the states, the Act should be liberally construed to carry out the Congressional purpose. To the extent that respondents, the government or others feel that federal antitrust regulation should supplant regulation by state administrators, it is the province of Congress and not the courts to make any such fundamental alteration.

ARGUMENT

I. AS AN EXPRESS EXEMPTION INCORPORATING THE PRINCIPLE OF COMITY BETWEEN THE FEDERAL GOVERNMENT AND THE STATES, THE McCARRAN ACT SHOULD BE CONSTRUED SO AS TO GIVE EFFECT TO ITS POLICY OF DEFERRING TO STATE REGULATION

Underlying the government's view of this controversy is its mistaken equation of the McCarran Act with other antitrust exemptions established, not by act of Congress, but by the judiciary as a means of reconciling competing regulatory policies. (U.S. Br. at 15) The government would thus erroneously apply the heavy presumption against *implied* antitrust immunities to construe the Act narrowly. (*Id.*) The McCarran Act, however, is an *express* exemption enacted in recognition of the special characteristics of the insurance industry.[1] Alone among the express exemptions, the purpose of the McCarran Act is to forego federal regulation (except in cases of boycott) in deference to regulation by the states. In view of the declared policy of Congress, the Act should not be read to grant antitrust immunity only to the extent necessary to obviate direct conflict with the antitrust laws, but rather should be interpreted liberally to carry out the Congressional intent. The term "business of insurance" should therefore be construed so as to effectuate Congress' policy of federal abstention where the states have undertaken to regulate the "business of insurance."

To the extent that it is felt (as the government apparently does) that federal antitrust regulation would benefit policyholders and health care providers more than regulation by state administrators, it is the province of Congress

[1] *See* National Society of Professional Engineers v. United States, 98 S. Ct. 1355, 1364, n. 14 (1978).

and not the courts to make any such fundamental alteration.[2] The legislative process, able to range beyond the narrow facts of this case and providing an opportunity for the states and consumers as well as health care providers and insurers to present their views, is the proper vehicle for resolving any policy decisions on the best form of regulation for the health insurance industry.[3]

[2] For these reasons, the government is incorrect in arguing that the "business of insurance" should be narrowly construed in cases of doubt because of the possibility that state regulation may not be effective. (U.S. Br. at 27, n.15) While the lower courts have generally refused to inquire into the efficacy of a state's chosen scheme of regulation (as the government notes, U.S. Br. at 27), this Court has indicated that the exemption will not be available where state regulation is a "pretense." *See* FTC v. National Casualty Co., 357 U.S. 560, 564 (1958). The government's presumption that state regulation would be less effective than federal antitrust regulation is also open to substantial question. Most states (like Texas) require prior approval of all new policy forms, and many also regulate rates. These comprehensive forms of regulation can be viewed as much more effective than hit-or-miss antitrust regulation left to the discretion of prosecutors and private plaintiffs. Additionally, virtually every state has adopted unfair trade practices legislation applicable to the insurance industry, protecting consumers against anticompetitive or deceptive practices to a degree far more specific than the general prohibitions of the federal antitrust laws.

[3] Both Congress and the Executive Branch are now considering proposals for possible modification of the McCarran Act. The National Commission for the Review of the Antitrust Laws, comprised of representatives from Congress, the judiciary, the Antitrust Division of the Department of Justice and the Federal Trade Commission, is undertaking a study of the McCarran Act exemption and will report its conclusions, including any recommended legislative changes, in December, 1978. In addition, the House Small Business Subcommittee on Capital, Investment and Business Opportunities is now considering a series of options concerning the McCarran Act. The National Underwriter, August 18, 1978, at 1.

II. THE "BUSINESS OF INSURANCE" INCLUDES BLUE SHIELD'S PHARMACY AGREEMENT BECAUSE IT IS AN INTEGRAL PART OF BLUE SHIELD'S CONTRACTUAL OBLIGATION TO PROVIDE BENEFITS TO ITS POLICYHOLDERS IN THE FORM OF GOODS AND SERVICES, RATHER THAN CASH

Ignoring the history and rationale of the prepaid health plan's tripartite method of delivering health insurance benefits in the form of services to the insured, the government argues that all provider agreements should be excluded from the "business of insurance" because petitioners propose an allegedly limitless definition of the term. The government warns that acceptance of petitioners' interpretation of the "business of insurance" would lead to expansion of that business to include: "[e]verything an insurance company does to make money or to reduce its costs . . ." (U.S. Br. at 8, 17-18); every contract between an insurer and a supplier of goods or services (U.S. Br. at 18); and every activity of an insurer which could be said to have the slightest impact on premium rates or benefits. (U.S. Br. at 27-28, 32) Because the government fails to recognize the distinctive characteristics of the kind of provider agreement long utilized by prepaid health service benefit plans, these predictions are groundless. More significantly, outright exclusion of all provider agreements from the insurance business would unrealistically confine that business to the delivery of cash benefits only.

Blue Shield's prescription drug benefit plan involves a tripartite arrangement between the policyholder, the insurer and the health care provider whereby: (1) the insurer receives regular payments from policyholders; (2) the policyholders receive needed prescription drugs from pharmacies; and (3) the pharmacies agree to accept payment from Blue Shield (plus a small payment in the

amount of the policy deductible, or less, from the insured) as full payment for the goods and services rendered to the policyholders.

The government's fundamental misconception of this insurance plan is that the Pharmacy Agreement is merely a means of reducing the cost of claims. While it is that, it is at the same time much more. As the district court found (App. 107a), the Pharmacy Agreement is the "business of insurance" because it is the essential *means* by which Blue Shield fulfills its basic obligation to furnish policy benefits in the form of goods and services rather than cash. Since the Agreement is the method of implementing the service benefit form of insurance, neither the policy nor the Agreement is operable without the other and together they constitute a unified plan of insurance.[4] The goods and services provided through the Pharmacy Agreement are, in short, the precise benefits which the policy promises to the insured.

The unity of the Pharmacy Agreement and the benefit provisions of the insurance policy is fully consistent with this Court's definition of insurance—in a case heavily relied upon by the government—as a "*guarantee* that at least some fraction of the *benefits* will be payable in fixed amounts." *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 71 (1959) (emphasis added). Blue Shield's "guarantee" that its insureds receive the benefits specified in the prescription drug policy is effectuated through the Pharmacy Agreement.

This tripartite structure of health service benefit insurance distinguishes the provider agreement from other

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[4] For the reasons discussed above, the government seriously understates the nature and express terms of the policy (*see* App. 54a-55a) when it contends that the policy only "implicitly" contemplates participating pharmacy agreements. (U.S. Br. at 28, n.16)

types of agreements between insurers and non-insurers. While, to use the government's hypotheticals (U.S. Br. at 18), an insurer might seek to limit expenses and reduce rates by contracting with a printer or a building owner to reduce printing costs or building rentals, such agreements do not constitute the fulfillment of the basic policy obligation to furnish benefits. Nor would satisfaction of that obligation be entailed in an insurer's agreement with an automobile manufacturer to install specially-designed bumpers on all cars. (U.S. Br. at 17-18) Indeed, even a requirement in the policy that the insurer enter into agreements to contain costs unrelated to benefits would be distinguishable from Blue Shield's Pharmacy Agreement, since the former would not relate to the furnishing of policy benefits.[5]

Further, contrary to the government's suggestion (U.S. Br. at 18), an agreement between an insurer and a supplier of goods or services to the *insurer* would not necessarily be included within the "business of insurance" because, among other things, such agreements do not deliver promised benefits directly to the insured.

The government's conception of the "business of insurance" also suffers from a wholly impracticable bifurcation between the contract with the policyholder and its method of implementation and settlement of claims. To exclude the Pharmacy Agreement would reduce Blue Shield's prescription drug insurance plan to unenforceable contracts, even though *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), explicitly identified the enforcement and reliability of policies as part of the "business of insurance."

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[5] Consequently, Blue Shield does not argue, as the government implies (U.S. Br. at 28, n.16), that the "mere reference" to the Pharmacy Agreement in the insurance policy is, standing alone, sufficient to immunize the agreement.

The government's unqualified exclusion of *all* provider agreements from the "business of insurance" would, in fact, limit that business to cash benefits only. Since provider agreements are indispensable to the delivery of service benefits to the insured, exclusion of such agreements from the "business of insurance" would necessarily result in the exclusion of the delivery of service benefits from the business. Such a myopic, unprecedented view of the "business of insurance" ignores the development of the entire prepaid health plan sector of the health insurance industry. Moreover, exclusion of the essence of the prepaid health plan's business—delivery of service benefits—from the "business of insurance" would contradict the Solicitor General's own admission that the "view" that "prepaid health plans are the business of insurance" is "not now in dispute." (U.S. Br. at 25, n.13) Exclusion of service benefits from the insurance business would also conflict with the government's concession that the method of policy implementation and claims settlement is functionally inseparable from the policy:

> The formula for the payment of insurance claims is an *integral part of any contract of insurance*, because it determines how much risk in involved, and how much of the risk will be assumed by the insurer. Such agreements among insurers *are no different in substance from agreements on the premiums to be charged* . . . . [U.S. Br. at 31 (emphasis added)]

In ignoring the linkage between the provider agreement and the policy benefits, both the government and respondents take a parochial and unrealistic view of what is of concern to policyholders. Rather than being of only ancillary importance to the insured, the provider agreement is one of the critical features demanded by policyholders who desire the service benefit form of coverage. The importance to insureds of the provider feature is best demonstrated by the fact that the insurance plan before this Court was conceived and initiated by policyholders

and beneficiaries (*i.e.*, the auto companies and U.A.W. members, respectively), not by Blue Shield or the pharmacies. *See* Brief for Motor Vehicle Manufacturers' Association as *Amicus Curiae*, at 11-12.

The tripartite structure of Blue Shield's prescription drug program is a direct response to the relative inelasticity of demand for medical services. Medical care is a necessity:

> A can cannot lose a better job than he holds nor can fire destroy a better house or automobile than he owns. But sickness may require service involving expenditures larger than a man's whole income during the period of disability or the rest of his life, and greater than his entire savings from previous income or gifts. The sick man's need is adequate health service, not a stated amount of cash.

Rorem, *Nonprofit Hospital Service Plans*, 1 Medical Care 135, 139 (1941). A promise from the insurer to pay specified cash benefits to the insured *after* he incurs health care expenses obviously does little to meet the insured's immediate need for services. Absent assurance of service benefits which the provider agreement enables the insurer to provide, the insured may be totally deprived of health care if the health care provider is not satisfied with the current financial status of the insured.

Full-coverage provider agreements, such as the ones involved in this case, eliminate these financial concerns of the insured by transferring the primary payment responsibility from the insured to the insurer. The insured can depend on receiving required health care services without regard to his ability to pay for the services directly. The distinctive tripartite relationship among insured, insurer and health care provider is therefore designed to respond to the three fundamental elements of the demand for health insurance benefits: (1) delivery

of benefits in the form of health care services; (2) transfer of the responsibility of fully paying for the services from the insured to the insurer; and (3) delivery of health care services at costs which are controllable and reasonably predictable to the insurer and the insured.

Prepaid service benefit insurance policies implemented through provider agreements were originated by Blue Shield and Blue Cross Plans before passage of the McCarran Act and have been an established part of the business of insurance ever since. Until the development of service benefits programs during the 1930s, the availability of health insurance was limited, and the insurance which was available paid limited cash benefits which often left the patient with substantial additional expenses at the time of illness and the providers without payment. I. S. Falk, *The Costs of Medical Care* 451-52 (1933).

Blue Cross Plans pioneered the development of the service benefit form of insurance to fill the gap left by the reluctance of commercial insurers to offer service rather than dollar benefits. D. M. MacIntyre, *Voluntary Health Insurance and Rate Making* 124 (1962). The rapid growth of enrollment in hospital service plans, from 200,000 subscribers in 1933 to four million in 1940, demonstrated "the demand for security against the unpredictable expense of health service." Norby, *Hospital Service Plans: Their Contract Provisions and Administrative Procedures*, 6 Law & Contemp. Probl. 545, 557 (1939).

The growth of non-profit hospital services plans based on contracts with providers was facilitated by the passage of enabling legislation which recognized the tripartite arrangement as a necessary and special type of insurance. Rorem, *Enabling Legislation for Non-Profit Hospital Service Plans*, 6 Law & Contemp. Probl. 528, 530, 534 (1939). Between 1934 and 1939, 24 states enacted leg-

islation modeled after the first statute, adopted in New York. *Id.* at 532.[6]

The hospital service plans were followed by the development of comparable tripartite service benefit plans for physicians' services. One of the first of these, the California Physicians Service ("CPS"), which later became a Blue Shield Plan, was incorporated in 1939. J. W. Garbarino, *Health Plans and Collective Bargaining* 108-09 (1960). Like prepaid hospital service plans, prepaid physicians' service plans were dependent upon agreements with participating physicians to fulfill the plans' obligation to provide services to subscribers. Burns, *The Michigan Enabling Act for Non-Profit Medical Care Plans*, 6 Law & Contemp. Probl. 559, 562 (1939). By 1944, when Attorney General Biddle testified before the joint Senate-House subcommittees considering passage of the McCarran Act,[7] tripartite prepaid health insurance plans were flourishing.

The government does not deny that service benefit policies were in widespread use prior to 1945 but resists the idea that these plans had been brought to Congress' attention. The case upon which the Attorney General's testimony was based, however, *American Medical Association* v. *United States*, 317 U.S. 519 (1943), involved the same sort of three-cornered service benefit plan as is present in this case. The insurer, Group Health, had contracted with its subscribers to provide benefits in the form of physicians' services. Group Health had then entered into agreements with doctors to render the services

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[6] *See also* the description of the Pennsylvania Nonprofit Hospital Plan Act of 1937 in Travelers Insurance Co. v. Blue Cross of Western Pennsylvania, 361 F. Supp. 774 (W.D. Pa. 1972), *aff'd*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973).

[7] Joint Hearing before the Subcommittees of the Committees on the Judiciary on S. 1362, H.R. 3269 and H.R. 3270, 78th Cong., 1st Sess. at 41 (1944).

covered by the policies. These agreements were identical in concept to Blue Shield's Pharmacy Agreements. The government, accordingly, is incorrect in concluding that the Attorney General's testimony related "only to prepaid health plans" and not to provider agreements. (U.S. Br. at 25, n.13; *see also* Resp. Br. at 69-70)

Even absent the Attorney General's testimony,[8] it is wholly unlikely that Congress was unaware of the widespread use of Blue Shield and Blue Cross service benefit plans. Certainly there is no indication in the legislative history that Congress intended to define the "business of insurance" in a manner inconsistent with its "customary understanding . . . at the time of enactment," that is, the state of the industry at the time of the Act's passage. *St. Paul Fire & Marine Insurance Co.* v. *Barry*, 46 U.S.L.W. 4971, 4975 (U.S. June 29, 1978).

The government's strained interpretations of the legislative history to the contrary are not persuasive. Congressional definitions of insurance emphasizing the insurer's lack of control over cost factors are not, as the government implies (U.S. Br. at 23, n.10), an indication that Congress intended to protect solely the risk-assuming function, but only reflect the obvious fact that assumption of risk was the special characteristic of the industry. Indeed, an important goal of the Act was to encourage more accurate assessment of costs and reduction of premiums by permitting "agreement[s] in advance" so that an insurer would know "what the terms of its obligation would be" and could estimate cost "factors, in their bearing upon rates and forms of policies . . . with a great reduction in expense." H.R. Rep. No. 873, 78th Cong., 1st Sess. at 9 (1943).

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[8] The Attorney General was not merely expressing his personal opinion, for, as he remarked, "the *Supreme Court* has . . . conceived of [the Group Health plan] as insurance." *Id.* at 42 (emphasis added).

While Congress understandably focused on rate-making and pooling of risk (*see* U.S. Br. at 24), since those practices were the subject of *United States* v. *Southeastern Underwriters Association*, 322 U.S. 533 (1944), Congress rejected language confining the exemption to those and related practices. *See, e.g.*, 79 Cong. Rec. 1444 (1945) (dialogue between Senators Pepper and O'Mahoney); H.R. 4444, 78th Cong., 2d Sess. at 2 (1944) and S. 12, 79th Cong., 1st Sess. at 3 (1945) (both limiting the exemption to specified agreements "between two or more insurance companies" where "expressly approved" by the state in advance). Similarly confining language (referred to by the government, U.S. Br. at 24-25) appeared in an early draft of the McCarran Act prepared by the National Association of Insurance Commissioners. The rejection of these specifically-worded provisions in favor of more general and inclusive language logically leads not to the conclusion drawn by the government, that only "the pooling of risks and the sale of policies" are covered by the Act (U.S. Br. at 24), but rather to the opposite conclusion that Congress intended for the exemption to be more broadly applicable.[9]

In view of the McCarran authors' deep concern over fostering insurance availability at reasonable rates,[10] they cannot have intended a construction of the Act that

[9] The government's references to rejection of language broader than that finally adopted (U.S. Br. at 23) are inapposite to the issue in this case. The phrase "acts in the conduct of [the insurance] business" was eliminated in conference without reference in the conference report, apparently because it was thought duplicative of the term "business of insurance." H.R. 3269, H.R. 3270 and S. 1362 were not rejected in favor of S. 340 and H.R. 1973 (the bills which, as amended, became the Act) because of any decision to narrow the scope of the activities to be exempted, but because Congress determined that the business of insurance should be exempted only in cases of state regulation rather than unconditionally.

[10] *See, e.g.*, H.R. Rep. No. 873, 78th Cong., 1st Sess. at 8, 9 (1943).

would inhibit or penalize the adoption of methods to provide comprehensive coverage at affordable rates. Prepaid health insurance programs arose out of the perilous financial circumstances of individuals during the Depression. H. E. Klarman, *The Economics of Hospital Service*, 29 Harv. Bus. Rev. 71, 78 (1951). However, the unique characteristics of tripartite service benefit plans are equally important in today's inflationary environment because they protect subscribers from the dual risks of illness and escalating prices. H. E. Klarman, *The Economics of Health* 38 (1965). Agreements with providers are the means by which Blue Shield predicts and controls the costs of delivering the promised prescription drug benefits, while continuing to offer competitively priced service benefit contracts demanded by consumers.

In sum, agreements with providers to furnish the goods and services specified as benefits in the insurer-policyholder contract are so closely related to the "type of policy" issued and so necessary to its reliability and enforcement, *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), as to bring them within the "business of insurance."

III. BLUE SHIELD'S PHARMACY AGREEMENT IS ALSO THE "BUSINESS OF INSURANCE" BECAUSE IT DETERMINES THE COSTS OF THE RISK UNDERWRITTEN

Because Blue Shield's Pharmacy Agreement is an integral part of a service benefit insurance plan, it is the "business of insurance" whether or not it has a substantial impact on rates. Nevertheless, the role of the Pharmacy Agreement in determining rates and preserving Blue Shield's solvency is an important, independent reason why the Agreement constitutes part of the insurance business. The government's attempt to minimize the consequences of the Pharmacy Agreement for Blue Shield's

rate-making and reliability ignores the functional relationship between rates and the cost of benefits.

A leading concern of the authors of the McCarran Act was the effect unrestrained competition might have on rate adequacy and insurer solvency.[11] The McCarran Act was therefore intended to immunize "rate-making" and "other activities of insurance companies" closely relating "to their status as reliable insurers." *Securities and Exchange Commission* v. *National Securities, Inc., supra,* 393 U.S. at 460. The foundation of insurer reliability is, of course, solvency, primarily maintained by setting rates at levels sufficient to cover expected losses. This does not suggest that any and all action by an insurer affecting its rates and financial stability is the "business of insurance," but only recognizes that Congress' and this Court's emphasis on solvency was not mere surplusage, as the government apparently feels. (U.S. Br. at 27-30)

Agreements which contain the costs of the risks covered by the policy should be distinguished sharply from incidental efforts to reduce an insurer's non-claims expenses (such as executives' salaries, or the "printing costs" and "building rental" hypotheticals mentioned by the government). (U.S. Br. at 18) This distinction is based on the truism that insurance rates are a direct function of loss experience. The most important objective in rate-making is to set rates at levels which are predicted to generate sufficient premium income to pay for the losses arising from the risk covered in the policy. As a result, in determining the rates it will charge for its prescription drug policies, the predominant factor considered by Blue Shield is the cost of the prescription drugs whose purchase is the only risk underwritten by the policy.

Because of the interdependence of rates and the cost of drugs, Blue Shield's agreements with pharmacies estab-

[11] *See* H.R. Rep. No. 873, 78th Cong., 1st Sess. at 9 (1943); S. Rep. No. 1112, 78th Cong., 2d Sess. at 6 (1944).

lishing the formula determining those costs necessarily has a substantial impact on rates. Apart from its causal relationship to rates, the formula for drug costs contained in the Pharmacy Agreement is crucial because in large part it determines the magnitude of the risk assumed by the insurer. The interrelationship of reimbursement formulas, rates and assumption of risk is, indeed, acknowledged by the government. (U.S. Br. at 31)

IV. THE GOVERNMENT'S RISK "UNDERWRITING" VERSUS RISK "REDUCTION" COMPARISON IS A DISTINCTION WITHOUT A DIFFERENCE AND IGNORES THE IMPORTANCE TO INSURERS OF ASSESSING AND CONTROLLING THE RISKS THEY ASSUME

This case undeniably presents a substantial question concerning the scope of the "business of [health] insurance" within the meaning of the McCarran Act. It does not, however, entail adoption of a new standard for determining the extent of that business, for *National Securities* has already established the controlling criteria for construing the Act consistent with the intent of its authors. The government's suggestion that new, multiple standards should be substituted for the *National Securities* analysis is not only confusing, but would not effectuate the Congressional purpose and would be unworkable in practice.

The government places special emphasis on a supposed distinction between "risk *underwriting*" or "risk spreading," [12] on the one hand, and "risk *reduction*," on the

[12] At the outset, we note that the government's uses of the terms "underwriting" and "risk spreading" are technically inaccurate. Properly defined, underwriting is the process of selecting risks "in order to determine which of those within a given class offers a probability of loss below that for the average of the class." R. Holtom, *Underwriting Principles and Practices* 123 (1973). Put differently, underwriting is the process of choosing the best customers

other. (U.S. Br. at 17 (emphasis in original)) That test, however, suffers from a fundamentally erroneous view of the insurance business. The government's novel theory is that an insurer's sole function is to assume indeterminate risk without the ability to assess or manage that risk, *i.e.*, to determine the manner in which the policyholder is guaranteed against loss, to contractually limit the risk assumed or to take steps to make the risk more predictable.

The fundamental purpose of all forms of insurance is to substitute "a small, definite cost (the premium) for a large but uncertain loss." [13] The process of determining the amount of premium to cover probable losses is known as the risk assessment process. Because the greater the degree of uncertainty about the magnitude of the risks assumed, the greater the probability that the insurer will not correctly assess its exposure and thus fail to cover actual losses with premium revenues, the risk assessment process necessitates efforts to reduce risks and to make them more readily predictable. In adopting the McCarran Act, Congress recognized the importance of measures to reduce or predict risks: "The most accurate determination of risks, premium rate, and forms of policy is desirable . . . in preserving the solvency of insuring companies, for there can be no true insurance unless rates are adequate." H.R. Rep. No. 873, 78th Cong., 1st Sess. at 9 (1943).

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among those within a given risk classification, all of whom must be charged the same rate. The government incorrectly uses the term to mean the basic function of the contract of insurance, that is, the insurer's assumption of risk. The term "risk spreading" (used by the government interchangeably with "risk underwriting") is not commonly used in the industry.

[13] R. Mehr and E. Cammack, *Principles of Insurance* 32 (5th ed., 1972). *See also* SEC v. Variable Annuity Life Insurance Co., *supra*, 359 U.S. at 71.

The reimbursement formula incorporated in the Pharmacy Agreement is a means of both limiting the magnitude of the risks assumed and improving the insurer's ability to predict future losses.[14] Since before the McCarran Act, it has been recognized that service benefit plans could succeed only if they could predict with reasonable accuracy the total costs of the health care services to be provided. I. S. Falk, *The Costs of Medical Care* 454, 475 (1933). Contracts with providers were essential to meeting that objective. *Id.* at 466.

The provider agreement's specification of a formula for reimbursement for health care services improves the predictability of the costs of health care services and affords the insurer some control over such costs in order to calculate and minimize premium rates. Without such a formula, fully paid service benefits could be provided only if the insurer were to follow the Fifth Circuit's suggestion and pay the provider "whatever" he charged. Such a development would result in a continuous, substantial and unpredictable increase in premium rates which would make service benefits programs almost impossible to administer and financially available to few, if any. H. E. Klarman, *The Economics of Hospital Service*, 29 Harv. Bus. Rev. 71, 79-80 (1951).

The flaws in the government's "risk spreading" standard stem from its transformation of the risk-assuming function from a necessary part of the insurance business to its entirety. The government draws its standard from *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65 (1959). The question before the Court in that case was whether a contract for

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[14] As a risk reduction device, the Pharmacy Agreement is similar to other mechanisms which are undeniably part of the "business of insurance" even though they do not constitute what the government terms "risk spreading." For example, insurers make frequent use of deductibles, exclusions from coverage and ceilings on total dollar liability.

payment of annuities was actually an insurance contract; the Court determined that it was not, since the issuer had not agreed to pay fixed benefits to the annuitant and had not assumed any risk. *Variable Annuity* thus held only that no true contract of insurance existed. It did not attempt to articulate any comprehensive definition of the "business of insurance" and certainly was not intended to limit that business to the naked assumption of risk.

The limited reach of *Variable Annuity* is further shown by the legislative history of the McCarran Act. While the assumption of risk is undoubtedly the *raison d'etre* of the insurance business, if Congress had intended to confine the reach of the exemption to that function, it had ample opportunity to do so explicitly. The Congressional intent is confirmed by rejection of early versions of the McCarran Act which would have limited the exemption to specified activities including, *inter alia*, such "risk spreading" devices as risk-pooling and reinsurance. *See* discussion *supra*, at 16.

Securities and Exchange Commission v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), interpreted the legislative purpose as to include within the scope of the McCarran Act all activities centrally connected to the insurer-policyholder relationship. While *National Securities* did not undertake an exhaustive listing of all activities within the business of insurance, it did indicate that much more than a skeletal agreement to assume risks was included. Specifically, the type of policy issued, its reliability, interpretation, and enforcement, as well as other activities which relate closely to insurer reliability and solvency, such as the setting of rates, the selling and advertising of policies and the licensing of companies and their agents, were described as parts of that business. 393 U.S. at 460. In applying the broad definition of the insurance business adopted by Congress and fleshed out

in *National Securities*, this Court and the lower courts have determined that a variety of practices other than so-called "risk spreading" are the business of insurance.[15]

In sum, both the legislative history and the plain meaning of the language of the statute, as construed by this Court, the lower courts and the states, demonstrate that the "business of insurance" is not limited solely to "risk spreading."

V. RESTRICTION OF THE "BUSINESS OF INSURANCE" TO HORIZONTAL AGREEMENTS AMONG INSURERS OR ACTIVITIES HAVING NO IMPACT ON OTHER MARKETS WOULD SUBVERT THE PURPOSES OF THE McCARRAN ACT

The government proposes a dichotomy between horizontal agreements, which are recognized to be exempt, and vertical agreements, which are said to be *per se* non-exempt. (U.S. Br. 31-32) The government's arguments appear to be: (1) that Congress did not intend to immunize vertical agreements; (2) that such vertical agreements do not sufficiently concern the relationship between insurers and insureds; and (3) that such agreements have their primary impact in a non-insurance market. None of these arguments finds any basis in the legislative his-

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[15] These include, for example: the selling and advertising of policies, FTC v. National Casualty Co., 357 U.S. 560 (1958); the standardization of policy clauses, American Family Life Assurance Co. v. Aetna Life Insurance Co., 368 F. Supp. 859 (N.D. Ga. 1973); the classifying of risks, Meicler v. Aetna Casualty & Surety Co., 506 F.2d 732 (5th Cir. 1975); and the settlement of claims, Proctor v. State Farm Mutual Automobile Insurance Co., 561 F.2d 262 (D.C. Cir. 1977), *pet. for cert. pending*, No. 77-580. Further, the states have universally acknowledged that the "business of insurance" includes more than so-called "risk spreading" by enacting statutes which, *inter alia*, regulate the relationships between insurers and their agents, prohibit unfair or deceptive sales and claims settlement practices and establish standards for preserving insurer solvency.

tory of the Act, in the decisions construing it or in the realities of the insurance business.

In the course of considering the McCarran Act, Congress was presented with the opportunity to limit the exemption to the horizontal agreements referred to by the government, but chose not to do so.[16] *See* discussion *supra* at 16. Moreover, the fact that the insurer-agent relationship is a vertical one was not intended to exclude that relationship from the scope of the Act where the specific activity in question was of substantial importance to the contract of insurance.[17] Indeed, the policyholder-insurer relationship itself is a vertical one, but it would, of course, be incongruous to argue that the McCarran Act did not cover this relationship merely because a buyer and a seller rather than competitors were involved. Neither could Congress have intended for the labels "vertical" and "horizontal" to be the sole determinants of McCarran Act immunity when, in practical terms, agreements such as Blue Shield's arrangements with pharmacies have a much more direct and profound effect on Blue Shield and the policyholder[18] than "horizontal" ar-

[16] The decisions construing the Act have therefore refused to exempt transactions between insurers where the effect on policyholders is minimal. *See, e.g.*, American General Insurance Co. v. FTC, 359 F. Supp. 887 (S.D. Tex. 1973), *aff'd*, 496 F.2d 197 (5th Cir. 1974) (insurance company mergers). Similarly, in *National Securities* it was the negligible impact on the policyholder of an insurance company's sale of securities which was dispositive, not the vertical configuration of the insurer-shareholder relationship.

[17] A principal allegation in the *Southeastern Underwriters* case was that the defendant rate bureau and its members had refused to do business with agents who represented companies which were not members of the combination. Congress reacted to this problem not by excluding vertical practices from the "business of insurance," but by including them within that business and subjecting boycotts to liability under § 3(b) of the Act. The government concurs that agreements between insurers and their agents may be the "business of insurance." (U.S. Br. at 26, n.14)

[18] The effect of the Pharmacy Agreement upon the policyholder is much more direct than the advertising of policies, FTC v. National

rangements which the government admits to be part of the insurance business.[19]

In its discussion of the purported distinction between vertical and horizontal agreements and particularly in its analysis of the labor exemption cases (U.S. at 34-36), the government also appears to argue that the Pharmacy Agreement is outside the scope of the McCarran Act exemption because it has some effect outside the insurance market. The availability of the exemption, however, cannot be dependent on the absence of any effects in non-insurance markets, since activities shielded by the McCarran Act necessarily have an impact in the market relating to the risk insured. To use the *Proctor* case as an example, a horizontal agreement among automobile insurers on the amounts to be paid in satisfaction of claims has an important effect on the market for automobile repairs; yet, the government concedes that such an agreement would nonetheless be exempt. (U.S. Br. at 31-32)

Neither would a "balancing" test between the effects in the insurance market and effects in the secondary market be consistent with Congressional intent. In enacting the McCarran Act, Congress has declared its policy choice as between the coverage of the antitrust laws and the states' interest in regulating the "business of insurance." Congress' express decision in favor of state regulation indicates the exemption is to be available without countervailing weight being given to allegedly anticompetitive effects in related, non-insurance markets as long as the Congressional purpose of protecting the insurer-

Casualty Co., 357 U.S. 560 (1968), or the licensing of agents, *cf.* Robertson v. California, 328 U.S. 440 (1946), both of which are within the "business of insurance."

[19] Among the horizontal agreements identified by the government are reinsurance pools (U.S. Br. at 24) and insurance association membership rules (*id.*).

policyholder relationship is fulfilled by exempting the conduct in question. The government's distorted labor immunity argument would engraft an unintended limitation upon the scope of the McCarran Act exemption, in essence making it "defeasible" merely by alleging anticompetitive effects in non-insurance markets. Had Congress intended such a limitation, certainly it would have stated so expressly. *Cf.* the boycott exception to the exemption contained in § 3(b) of the Act, 15 U.S.C. § 1013(b) (1976).

Even if it were appropriate to balance the alleged anticompetitive effects of the Pharmacy Agreement in non-insurance markets against the interests protected by the McCarran Act in order to determine the availability of the exemption, the Agreement does not have anticompetitive effects in the retail market for prescription drugs. The government devotes a considerable portion of its brief to acknowledging this fact. (U.S. Br. at 10-14) The key to analysis of the competitive effects of the Pharmacy Agreement lies in the contrariety of the interests of Blue Shield (and its subscribers) and the pharmacies. Blue Shield and its policyholders do not desire to stabilize prescription drug costs at artificially *high* levels, but through contractual arrangements to prevent them from increasing as fast as they might. The purpose and effect of the Pharmacy Agreement are thus fully consistent with the consumer protection objectives of the antitrust laws. (*See* U.S. Br. at 12) Conversely, the economic interest of participating pharmacies runs counter to accepting a prohibitively low level of reimbursement. As a result, the reimbursement level in the Pharmacy Agreement is determined in a competitive framework. It must also be emphasized that nothing in the McCarran Act exempts either Blue Shield or the pharmacy petitioners from acts of boycott against either pharmacies or policyholders.

St. Paul Fire & Marine Insurance Co. v. *Barry*, 46 U.S.L.W. 4971 (U.S. June 29, 1973).[20]

VI. SINCE THE PHARMACY AGREEMENT IS PROTECTED, McCARRAN ACT IMMUNITY IS EQUALLY AVAILABLE TO PARTICIPATING PHARMACIES

Respondents, as does the government, argue that Blue Shield's Pharmacy Agreement is not a part of the "business of insurance" because of its impact in the market for prescription drugs. (Resp. Br. at 48) In other respects, however, respondents take a very different approach from the government, arguing (with some inconsistency) that immunity is unavailable: (1) to Pharmacy Agreements only when they have anticompetitive effects (*id.* at 33-34); (2) to all non-insurance companies

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[20] While respondents have raised what they term "boycott" allegations, their claims are far different from those before the Court in *Barry*. The *Barry* plaintiffs had alleged a total refusal to deal, since they claimed they had been wholly unable to purchase insurance from three of the four insurance company defendants. The outcome in *Barry*, therefore, did not rest on allegations that the insurers had refused to deal except at stated prices or stated coverages. Nor did *Barry* involve a claim that the insurers were exerting only economic coercion on prospective policyholders. In contrast, the respondents in this case contend they are being "boycotted" *only* because Blue Shield's policies: (1) contain an economic incentive for subscribers to patronize participating rather than non-participating pharmacies; and (2) offer an incentive for policyholders to utilize participating pharmacies because they are not required first to purchase drugs out-of-pocket and then seek reimbursement from Blue Shield. These purely economic incentives do not amount to a boycott. As recognized in *Barry*, enforcement by non-economic coercion (*e.g.*, total refusals to deal) is necessary; otherwise, the boycott exception would extend to all violations of the Sherman Act, an extension which would totally subsume the McCarran exemption. 46 U.S.L.W. at 4977. The record demonstrates (McDonald Aff., App. 48; Johnson Depo., App. 147a) and the government agrees (U.S. Br. at 11) that Blue Shield offered the opportunity to all licensed pharmacies in Texas to enter into the Pharmacy Agreement.

(*id.* at 113); and (3) to health care providers when it is alleged that they have agreed in horizontal fashion to enter into vertical contracts with the insurer. (*Id.* at 54)

Respondents concede they are not "attacking contracts between insurers and providers in general and are not alleging that all such contracts are outside the business of insurance." (Resp. Br. at 33) Respondents' argument is instead that provider agreements cannot benefit from the McCarran Act whenever a plaintiff alleges that the effect of the agreement is to fix prices. (*Id.*) To contend that the McCarran Act only protects activities that do not arguably come within the scope of the federal antitrust laws, however, would defeat the very purpose of the exemption.

The argument that non-insurers can never partake of the exemption is similarly flawed. The pharmacy petitioners do not claim that if Blue Shield as an insurer is immune, they too are automatically shielded. Rather, they argue that if the Pharmacy Agreement is part of the "business of insurance" then both signatories necessarily must be immune to effectuate the Act's purposes. The government agrees, correctly interpreting analogous cases exempting collective bargaining agreements to mean that if the agreement is exempt, "neither party to the agreement is liable . . . ." (U.S. Br. at 35, n.23) Any other interpretation would eviscerate the Act by limiting immunity to insurers but exposing providers to the penalties of the federal antitrust laws.

Respondents misconstrue the *National Securities* decision, which, while holding that not all activities of insurance *companies* were the "business of insurance", did not even hint that the activities of non-insurance companies could never be part of that business. Instead, emphasizing that the McCarran Act "refers not to the persons or companies who are subject to state regulation, but to laws 'regulating the *business* of insurance' ", 393 U.S. at

459 (emphasis in original), *National Securities* establishes that the scope of the Act includes *all* conduct within the "business of insurance" regardless of the identity of the actors.[21]

The McCarran Act can be contrasted with other express antitrust exemptions conferring immunity on the basis of the identity of the potential recipients, not the nature of their conduct. For example, this Court has recently determined that the Capper-Volstead Act, 7 U.S.C. § 291 (1976), does not extend to packers or processors in an essentially vertical relationship with poultry farmers since the express language of the act is limited to "farmers." *National Broiler Marketing Association* v. *United States*, 98 S. Ct. 2122 (1978). Consequently, the exemption was restricted to cooperative associations *all* of whose members independently qualified for the exemption as farmers. In contrast, the McCarran Act refers to

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[21] Indeed, the Court noted that agents as well as insurers were potentially eligible for the Act's protections. 393 U.S. at 460. In addition to misconstruing *National Securities*, respondents stretch the lower court opinions on which they rely well beyond their actual holdings. The court in Meicler v. Aetna Casualty & Surety Co., 506 F.2d 732 (5th Cir. 1975) focused, not on the fact that every defendant was an insurance company, but rather on the fact that the challenged activities—risk classification and rate-making—were obviously intended to be immunized by McCarran. In Pastor v. Hartford Fire Insurance Co., 1976-1 CCH Trade Cas. ¶ 60,783 (C.D. Cal. 1976), the district court found that the challenged activities of the Los Angeles County Medical Association were not a part of the business of insurance since they included an alleged conspiracy to monopolize the practice of medicine as well as physicians' liability insurance and, in any event, were not regulated by the State of California. *Id.* at 68,398. Lastly, Center Insurance Agency v. Byers, 1976-1 CCH Trade Cas. ¶ 60,940 (N.D. Ill. 1976), dealt with an alleged conspiracy to pirate trade secrets and convert proprietary advertising programs for the benefit of the insurance companies and not for the benefit of the insureds. Although there is a reference in *dictum* to non-insurance companies being outside the Act's immunity, the district court squarely held that the challenged activities of *all* the defendants "did not involve the 'business of insurance' and therefore are not exempt . . . ." *Id.* at 69,125 (emphasis added).

the "business of insurance" and "every person engaged therein," rather than to "insurance companies," indicating a conduct-oriented test. Congress has thus expressed no similar intent that the exemption be available only when an insurer deals with another insurer.[22]

The McCarran Act would also become a hollow immunity if antitrust plaintiffs could defeat the exemption merely by alleging, as respondents assert they have done (Resp. Br. at 119), that participating pharmacies entered into Pharmacy Agreements on a joint rather than unilateral basis. At the outset, it is important to realize the limited nature of respondents' "horizontal conspiracy" theory. As the government carefully notes, the complaint does not allege facts sufficient to "establish that the participating pharmacies conspired among themselves to obtain a price for distribution higher than they otherwise could obtain." (U.S. Br. at 14, n.6) Neither do respondents sufficiently allege that the Pharmacy Agreement is the means by which participating pharmacies engage in predatory pricing, since the complaint does not assert that the "pharmacy agreements entail sales at less than marginal costs . . ., and the complaint thus does not set out an essential element of predatory pricing." (*Id.*) Thus,

[22] The authorities cited by respondents to the contrary do not involve antitrust exemptions for specified types of conduct. Timken Roller Bearing Co. v. United States, 341 U.S. 593 (1951), did not even involve—as respondents concede (Resp. Br. at 118)—a question of exemption but rather the issue whether inability to obtain jurisdiction over foreign co-conspirators precluded jurisdiction as to a United States corporation. Sloan Shipyards Corp. v. United States Shipping Board Emergency Fleet Corp., 258 U.S. 549 (1939), involved the application of sovereign immunity to a corporation acting as agent of the United States. Unlike the McCarran exemption, sovereign immunity is based upon the identity of the actor in terms of whether or not it assumes the characteristics of a governmental entity. Finally, the only McCarran Act case cited by respondents that is remotely relevant, Pastor v. Hartford Fire Insurance Co., *supra*, expressly left open the question of whether one alleged participant to an antitrust conspiracy may be sued if its co-conspirator is statutorily immune. 1976-1 CCH Trade Cas. ¶ 60,783 at 68,398 (C.D. Cal 1976).

respondents' allegation is reduced to a claim that the pharmacy petitioners agreed only to accept the Agreement offered by Blue Shield, an Agreement which is by itself part of the insurance business. Even as to this allegation, the record evidence is undisputed that there was no collusion between the pharmacy petitioners.[23]

Because respondents do not allege that the pharmacy petitioners' "combination" agreed on anything beyond the express terms of the Pharmacy Agreement, any injury purportedly suffered by respondents would be proximately caused by that Agreement. But Blue Shield's service benefit agreements with pharmacies are exempt as part of the "business of insurance" regulated by Texas. Respondents thus do not allege in this case any injury arising "by reason of anything forbidden in the antitrust laws . . . ." Clayton Act, § 4, 15 U.S.C. § 15 (1976).

VII. ALTHOUGH THE QUESTION OF STATE REGULATION IS NOT BEFORE THE COURT, TEXAS HAS REGULATED THE PHARMACY AGREEMENT THROUGH ITS POLICY APPROVAL AND UNFAIR TRADE PRACTICES LEGISLATION

The question whether Texas has regulated Blue Shield's Pharmacy Agreement was expressly left undecided by the court of appeals (App. 123a), was not presented in the petition for certiorari or opposition and is not therefore before the Court. Respondents' argument (Resp. Br. at 20) that the State Board of Insurance has no regulatory authority over the Agreement or participating pharmacies, however, cannot be left unchallenged.[24]

[23] The evidence before the district court, uncontested by affidavit or other evidence from respondents, demonstrates that there was no conspiracy, horizontal or otherwise. (App. 45a, 95a, 98a; *see* Rule 56(e), Fed. R. Civ. P.)

[24] The government addresses the state regulation issue only briefly (U.S. Br. at 29, n.18). Petitioners do not argue, as the government implies, that regulation by Texas is determinative of whether the

Petitioners have never disputed that Texas insurance officials have no regulatory jurisdiction over pharmacies *qua* pharmacies. However, it is abundantly clear that the State Board had the power to regulate Blue Shield's prescription drug plan, by which it necessarily regulated the Pharmacy Agreement. Specifically, by approving or disapproving the issuance of the prescription drug policy, the State Board had the power effectively to prevent or authorize Blue Shield to enter into agreements with participating pharmacies. The State Board also had the power to determine the provisions of the Pharmacy Agreement through its approval or disapproval of the policy provisions upon which the Agreement was based.

Texas first exercised these approval powers and also applied its unfair trade practices statute, the same statute found to be sufficient state regulation in *Federal Trade Commission* v. *National Casualty Co.*, 357 U.S. 560 (1958), to disapprove Blue Shield's policy and Pharmacy Agreement on the stated ground that there was a "differentiation in benefits as between 'participating provider' dispensed drugs and 'non-participating provider' dispensed drugs." [25] (App. 365-366a) The state's subsequent order authorizing issuance of the policy was also directed to the tripartite nature of the prescription drug plan, which was described as utilizing "drug service contracts, . . . the

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regulated conduct is the "business of insurance" or that Texas could by statute bring practices outside the "business of insurance" within the reach of the McCarran Act. Petitioners do contend that the views of Texas authorities should be considered. The government, in fact, elsewhere admits that the views of state insurance commissioners "are particularly significant because the [McCarran] Act evolved from a draft bill the [National] Association [of Insurance Commissioners] submitted to Congress." (U.S. Br. at 24)

[25] A second and independent ground for initially disapproving the service benefit arrangement was that it violated the Texas antitrust laws, which are specifically made applicable to the "business of insurance." (App. 365a-366a; *see also* Addendum to Brief for Petitioners at Add. 14a-17a)

insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policyholders." [26] (App. 370a-371a) Finally, the state approved in 1974 a virtually identical prescription drug policy. (App. 374-386a) The state's orders are uncontrovertible evidence that Texas considered the very practices now in issue to be part of the insurance business subject to its insurance code and that the state undertook to regulate those practices.[27]

The specific manner in which Texas has chosen to regulate Blue Shield's policies and Pharmacy Agreements—prior approval of policies and prohibition of unfair practices—is immaterial, for the basic purpose of the McCar-

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[26] The State Board's decision to rescind its disapproval and exempt Blue Shield from the policy approval requirement of the Texas Code was made so as not to put Blue Shield, a regulated domestic insurer, at a competitive disadvantage with unregulated, out-of-state insurers offering similar policies. (App. 370a-373a) Blue Shield's insurance plan remained subject to all regulatory statutes, including the unfair practices law. (*See* Brief for Petitioners at 7, n.8) The Texas Insurance Commissioner also referred the policy and the Agreement to the State Attorney General for appropriate action under the state's antitrust laws. (App. 367a-368a; 372a-373a) The policy filed in 1974 was approved rather than exempted. (App. 385a-386a)

[27] In a number of instances, respondents misrepresent the record as it relates to state regulation. For example, respondents claim that Steve G. McDonald, counsel for Blue Shield, testified that the Pharmacy Agreement need not be filed with the State Board for its approval. (Resp. Br. at 18) Portions of Mr. McDonald's deposition testimony not included in the Appendix and not quoted by respondents demonstrate that he was not referring to the Pharmacy Agreement here in issue, but to a Participating Plan Agreement implementing, for employees of Mack Trucks, Inc. living in Texas, a different policy issued and approved in another state. (McDonald Depo. at 20)

While respondents' assertions of a lack of state regulation are baseless, at most they raise factual questions the resolution of which would be proper only at the trial court level since the state regulation issue was decided in favor of petitioners on motion for summary judgment.

ran Act was to permit the states freedom to choose the desired form of regulation. *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 408 (1946).

VIII. CONCLUSION

For the foregoing reasons, the judgment of the Court of Appeals for the Fifth Circuit should be reversed.

Respectfully submitted,

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